
Acceptance of Financial Responsibility (For Minors)

I certify that I am at least 18 years of age, and I agree to be responsible for all premiums and copayments owed by the individual(s) named below. This includes premium payments to Basic Health for their coverage, and copayments owed to the contracting provider or health plan when services are received.

Signature

_____/_____/_____
Date

Printed Name

Street Address

City

State

ZIP

Mailing Address (if different from above)

City

State

ZIP

Applicant or Subscriber Information

Basic Health subscriber ID number (if known): _____

Name of applicant or subscriber: _____

Names of other family members enrolled:

Permission to share Basic Health account information

To: Basic Health

I give my permission for Basic Health to share information regarding the status of my Basic Health account and any premium payments due with the person who has agreed to be held financially responsible for my Basic Health coverage (above). This permission will end when the person above is no longer financially responsible for my coverage, when I reach 18 years of age, or when I notify Basic Health that it is cancelled.

Applicant's or subscriber's signature

_____/_____/_____
Date